authorities to aid law enforcement officers and prosecutors in gathering evidence and building cases to bring violent criminals to justice.

These grants also may be used to operate training programs for victim advocates and counselors. Many victims of domestic violence and sexual assault are afraid to retell their stories to friends, family or a counselor. Training people to know how to assist victims of domestic violence is a necessary tool in fighting this epidemic and preventing future abuse.

The 2000 reauthorization of the Violence Against Women Act created new grants to be used to address violence issues on college campuses. It also authorized new grant monies to assist victims of violence with legal concerns and to address violence against the elderly and disabled.

Continuing its commitment to fighting violence and domestic abuse, Congress provided generous monies again this year to the Department of Justice's Office on Violence Against Women.

It is important to recognize the work and dedication as well of groups committed to increasing awareness surrounding domestic violence through education campaigns, intervention, and counseling.

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Mr. Speaker, the National Network to End Domestic Violence, the National Coalition Against Domestic Violence and the National Center for Victims of Crimes are just a few groups that are active in ridding our Nation, our homes, of violence. Many State and local groups across the country also work day to day to prevent violence, aggressively enforce penalties, and counsel victims of violent crimes.

Mr. Speaker, I hope that the Congress will continue to fund outreach and education programs and encourage individuals to work together to change attitudes towards these crimes. It is clear that we are making progress in this area, but we must continue to work together to eradicate violence against women. To all of those working at the local, State and Federal level to eliminate domestic violence and sexual abuse, we express our thanks to them for their selfless efforts and dedication. We hope that our support in the Congress will assist them in this very important battle and fight.

HONORING 100TH ANNIVERSARY OF UNIVERSITY OF PUERTO RICO

The SPEAKER pro tempore (Mr. SIMMONS). Pursuant to the order of the House of January 7, 2003, the gentleman from Puerto Rico (Mr. ACEVEDO-VILÁ) is recognized during morning hour debates for 5 minutes.

Mr. ACEVEDO-VILÁ. Mr. Speaker, this week Puerto Rico is celebrating the 100th anniversary of the University of Puerto Rico, our oldest and most prominent higher education institution. One hundred years ago, the University of the Puerto Rico was founded as a training center for teachers, and opened its doors with just 173 students. Since then, the UPR has evolved to become the foremost Hispanic-serving institution in the United States, and one of the leading universities in the Spanish-speaking world. Today the UPR offers 485 academic programs in practically all areas of learning and has a student body of about 70,000 students.

The political, cultural and economic development of Puerto Rico has been closely linked to the UPR. From governors, Supreme Court judges, and NASA engineers to world-renowned authors and poet laureates, all can be found in the UPR alumni. I am proud to be one of thousands of alumni of the UPR that today pay tribute to our alma mater. We look forward to another 100 years of excellence.

Mr. Speaker, congratulations to the people of Puerto Rico, to the University of Puerto Rico, to its students, and to its alumni on its 100-year anniversary.

COVER THE UNINSURED WEEK

The SPEAKER pro tempore. Pursuant to the order of the House of January 7, 2003, the gentleman from Florida (Mr. STEARNS) is recognized during morning hour debates for 5 minutes.

Mr. STEARNS. Mr. Speaker, this week is Cover the Uninsured Week where lawmakers, the media, and our constituents will consider how we can help provide health care coverage for some 35 million Americans. No doubt some will pronounce that the answer lies in a single payer, universal health care coverage program. I say there are better ways. Why? Let us look at countries that do have national health care in place and see its problems.

Let me share with Members a story I read in a February 13 article in the New York Times about the growing lag on the Canadian health care system. According to this article, a Canadian government study shows that 4.3 million Canadians, 18 percent of those who saw a doctor in 2001, had a problem getting tests or surgery done in a timely fashion. Three million could not find a family physician. Canada spends $86 billion on the health care. Only the United States, Germany and Switzerland spend more as a proportion of economic output, but budget cuts since the early 1990s have impeded efforts to keep health care up to date.

Waiting lines have also increased because an aging population is placing more demands on the system. A study by the Fraser Institute recently concluded that patients across Canada experience waiting times of 16.5 weeks between receiving a referral from a general practitioner and undergoing treatment in 2001–2002, a rate 77 percent longer than in 1993.

Mr. Speaker, can Members imagine an insured American putting up with a wait for 4 months? As Members can imagine, those with the means to seek other options do not, due to what the Canadians call ''line jumping'' by the affluent and well-connected.

While the goal of many who recommended socialized health care is egalitarian, equal health services for all, that is exactly what they get, an equally long wait for all. But if a Canadian has money, they just fly south to a private physician in the United States. My State of Florida is notoriously a haven for Canadian snowbirds to winter in and seek medical care.

Last month I had members of various Canadian provincial governments visit me asking how they could work out an arrangement and fee schedule with physicians in Florida to provide services to them.

And to point out another example of the erosion of egalitarian goal that national health care is supposed to provide, there is an ad for an up-scale maternity service in London's Portland Hospital. It points out women do not have to be famous to give birth there, they just need to have money. Deluxe private suites, champagne, and a beauty salon are just among some of the amenities. I thought all English women could receive quality, timely obstetrical care in their assigned hospital. But why then would the Duchess of York and supermodel Jerry Hall choose to have their babies outside the socialized system, because those who can afford to pay want choice, and we should provide nothing less for all Americans.

To seek a legacy in his final years of office, Canada's Prime Minister Jean Chretien has agreed to spend $9 billion more over the next 3 years. Fortunately for Canadians, the system's shortfalls have opened the way for tentative but growing movements toward privately managed medical services.

Let us resolve today to promote choice and opportunity for the uninsured to obtain the health care plan that works best for them. One of the major ways is to institute a tax parity into health insurance. The 90 percent of us who receive our health insurance through our employers are receiving a substantial tax benefit. We should extend this to those in the individual market also.

When this Congress convened on January 7, I introduced my bill, H.R. 198, that would allow any tax filer to deduct 100 percent of the cost of their health insurance as well as nonreimbursed prescription drugs. Currently, only the self-employed can deduct 100 percent, but what about the unemployed or the retired? H.R. 198 would help them also. Likewise, many of my colleagues have introduced legislation to provide tax credits for Americans to use for purchasing health care. These are all ways we can help cover the uninsured and enable them to purchase the health insurance of their choice.

LONG LINES MAR CANADA'S LOW-COST HEALTH CARE

(By Clifford Krauss)

TORONTO. Feb. 11—During a routine self-examination last May, Shirley Magee found

a lump on her breast. Within weeks she had it and some lymph modes removed. So far so good, until it came to the follow-up therapy.

Mrs. Magee, a 55-year-old public school secretary, researched her condition on the Internet, and read that optimally, radiation treatment should begin two weeks after surgery. But the local provincial government clearinghouse that manages the waiting time for radiation therapy told her she had to wait until the end of September—nearly three months after her surgery—to begin treatment.

''I was supposed to feel lucky I got in so quickly,'' said Mrs. Magee, still viscerally annoyed though she has since successfully completed her radiation regime. ''It's a horrible feeling that something in your body is ticking that you have no control over. If I were a politician's wife I wouldn't have had to wait.''

Long heralded for giving all Canadians free health insurance and paying for almost all medical expenses, the health care system founded in the 1960's has long been the third rail all of Canadian politics; not to be touched by private hands, nor altered by Parliament.

But growing complaints about long lines for diagnosis and surgery, as well as widespread line-jumping by the affluent, and connected, are eroding public confidence in Canada's national health care system and producing a leading issue for next year's national elections.

A recent government study indicated that 4.3 million Canadian adults—or 18 percent of those who saw a doctor in 2001—reported they had difficulty seeing a doctor or getting a test or surgery done in a timely fashion. Three million Canadians are unable to find a family physician, according to several private studies, producing a situation all the more serious since it is the family doctor who refers patients to specialists and medical testing.

''The sky isn't falling, but things are not rosy,'' said Dr. Dana W. Hanson, president of the Canadian Medical Association. ''Nevertheless if things are not fixed, the sky may fall.''

Canada spends $86 billion a year on health care—only the United States, Germany and Switzerland spend more as a proportion of total economic output—but budget cutbacks since the early 1990's have impeded efforts to keep health care up to date. A recent report by the Senate's Standing Committee on Social Affairs. Science and Technology indicates that well over 30 percent of the country's medical imaging devices are obsolete.

Overworked technology is one reason for the long lines; others include a shortage of nurses and inefficient management of hospital and other health care facilities, according to several studies.

Waiting times have also increased because an aging population has put more demands on the system, while the current generation of doctors is working fewer hours than the last.

Waiting can occur at every step of treatment. A study by the conservative Fraser Institute concluded that patients across Canada experienced average waiting times of 16.5 weeks between receiving a referral from a general practitioner and undergoing treatment in 2001–2002, a rate 77 percent longer than in 1993. The recent Senate report noted that waiting times for M.R.I., CT. and ultrasound scans grew by 40 percent since 1994.

''Waiting lists are the hornets' nests that are jeopardizing the system,'' said Dr. Tirone E. David, professor of surgery at the University of Toronto. He noted that Ontario residents needed to wait an average of two months to see a cardiologist unless it was an emergency, queries for angiograms took four to six weeks, and waiting times between initial examination and micro-valve repairs could take as long as six months.

''It wasn't that way 15 years ago,'' Dr. David added. ''It does not alter the ultimate outcome, but there's an anguish and uncertainty when a person feels their life is in a holding pattern for up to a year.''

Defenders of the Canadian system note that only patients waiting months for nonemergency care, like treatments for cataracts and hernias skew the waiting time statistics.

And they argue that within life expectancy of 78 years, Canadians still enjoy one of the longest life expectancies in the world, slightly higher than the United States where 41 million people have no health insurance.

Still recent polls show that while Canadians want to keep their national system they are worried about its future effectiveness.

''I don't think there's a lot of patience among the public for a lot more study,'' said Deputy Prime Minister John Manley in a recent interview noting that his own driver needed to wait a year for hip replacement surgery. ''There's not a lot of time to deal with it.''

In response to the growing concerns, Prime Minister Jean Chretien and the Senate conducted studies of the system, that concluded in recent months that shortages of doctors nurses and diagnostic equipment had caused at least some deterioration of care over the last 10 years.

Seeking a legacy in his final year in office. Mr. Chretien agreed last week to spend over $9 billion more over the next three years on programs to improve diagnostic equipment, primary care, drug coverage and home care. But the provincial and territorial premiers say that isn't nearly enough to alleviate shortages of services, particularly in rural areas.

The system's shortfalls have opened the way for tentative but growing moves toward privately managed medical services and user fee in return for quicker service. A hospital in Montreal has begun charging fees for some surgical procedures and renting operating rooms to patients for several hundred dollars an hour. A Vancouver hospital has begun selling full-body C.T. scans for $860.

In an effort to reduce waiting lists, the provinces of Alberta, Nova Scotia and Ontario have established about 30 private M.R.I. and C.T. clinics, some of which offer nonemergency services to be paid for by private insurance.

''With the system cracking at the edges and waiting lists growing, people will eventually stay ''all right, let me pay, said Dr. Tom McGowan, president of Canadian Radiation Oncology Services, Canada's first for profit cancer radiation treatment center which has treated nearly 2,000 patients since it opened in Toronto two years ago. (Patients still pay nothing at the radiation clinic; Dr. McGowan is paid by the province and receives bonuses if he surpasses productivity targets.)

The Ontario provincial government allowed Dr. McGowan to open his night clinic after it was forced to send 1,650 cancer patients to the United States for radiation treatments during a 25-month period in 2000 and 2001 because of waiting lists that were up to 16 weeks long.

Dr. McGowan said the emergency, which cost the province $20 million in travel costs, was not rooted in a shortage of equipment nor staff but inefficient public management. Whatever the reasons his patients are quick to tell horror stories about their waits for diagnostic tests and treatments.

''Your worst fear is it is going to grow while you are waiting.'' said Pat McMeekin, a 53-year-old hospital clerical worker, recalling the two months she had to wait between a mammogram and the first of two biopsies confirming she had breast cancer last summer. ''When you have something you want to take care of it and be done with it.''

TOLERANCE

The SPEAKER pro tempore. Pursuant to the order of the House of January 7, 2003, the gentleman from Indiana (Mr. PENCE) is recognized during morning hour debates for 5 minutes.

Mr. PENCE. Mr. Speaker, I was here on September 11, 2001. I saw the skies filled with mud-brown smoke rising from the devastation at the Pentagon. I felt that anger that every American felt then and that continues to simmer in the lesser angels of our nature to this very hour.

There is in my heartland Indiana district a small mosque in Muncie, Indiana, where each weekend a small community, less than 1,000 people of Arabic descent, gather to practice their religious faith, each of them contributing in important ways in our community. They reached me in the immediate hours after September 11 and expressed to me their concern as family people for their well-being in the wake of this attack that was unanimously effected by Arab extremists against our country.

It was then that I issued a statement I read again today. I said then that the terrorists who attacked the World Trade Center and the Pentagon are not representative of the overwhelming majority of Arabs or Muslims in the United States, and we could not allow anger at this horrible act to lead us to hate or discriminate against innocent individuals who happened to be of Middle Eastern descent. I said that terror has no regard for religion or ethnicity, and if we attack the innocent simply because of their ethnic status, we are no better than the terrorists who attacked us.

So we come to these days in which we find ourselves again perhaps on the precipice of a war in the Middle East, with the news in our Muncie newspaper this weekend that a recent graduate of Ball State University was arrested on terrorist charges at his home in Idaho. I thought with this news and the potential for war abroad and terrorist attacks at home, it would be appropriate to rise again to remind the people of my district and the State and even of this country that we cannot allow the hatred that terrorists and their sympathizers possess to inflame our hearts and distort our communities.

I urge my fellow citizens to continue to embrace those ideals of the Declaration of Independence, and understand while we believe and have built a Nation founded on the premise that all men are endowed by our Creator with certain inalienable rights, we cannot and must not give voice of persecution or permit acts of discrimination